THE ROLE OF FAMILY IN HEALTH AND HEALTHCARE UTILIZATION AMONG ELDERLY

A Dissertation
Submitted to the Department of Humanities and Social Sciences,
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Requirement of the Award of the Degree of

MASTER OF ARTS IN DEVELOPMENT STUDIES

Submitted By

Sureswari Das
Roll No. – 410HS1004

Under the Guidance of
Prof. R.K. Biswal

Department of Humanities and Social Sciences
National Institute of Technology
Rourkela-769008
Odisha
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CERTIFICATE

This is to certify that this project paper "Role of Family in Health and Healthcare Utilisation" submitted by Sureswari Das for the partial fulfilment of the requirement for the award of Master of Arts (M.A) in Development Studies course, is a record of bonafied work carried out by her in the department of Humanities And Social Sciences, National Institute of Technology, Rourkela. The work incorporated in this project paper has not been submitted for the award of any diploma/degree elsewhere. She is sincere and hardworking.

I wish every success in her life.

Prof. R.K. Biswal
Supervisor
Department of HS
NIT,Rourkela-769008

DECLARATION

I Ms Sureswari Das do here by assert that the project paper **"Role of Family in Health and Healthcare Utilisation"** submitted to the department of Humanities and Social Sciences in partial fulfilment of the requirement for the Degree of Master of Arts in Development Studies is solely done by me and resembles no similarity with any other papers presented so far by anybody else.

Name- Sureswari Das

Roll No- 410hs1004

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"With God all things are possible." This saying sums up how through God's intervention this thesis has been successfully completed. I thank the Lord for favours because I couldn't have made it with him, particularly the hard times of the past few months. Thank you for motivating me to work harder and for the many sacrifices of time and energy you dedicated just to see me thrive.

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Name- Sureswari Das

Roll No- 410hs1004

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ABSTACT

Objective:

- To know the present status of family system in odisha, changes they were undergoing and implication of such trend on health of the elderly population and to examine the perception of elderly regarding their family support.
- To examine the pattern of health and healthcare utilization among elderly.

Methods:

A study was carried out in Santoshpur village of Sundergarh district, Odisha. Verbal informed consent was taken from the participants. The questions included demographic profile, satisfaction with current family system, opinions about changing trends of family systems, dependency and decision making of the elderly on children and their implications on health. This questionnaire also includes the questions related to pattern of healthcare utilization. Questionnaire and Interview are employed to collect the information Analysis was done using SPSS 15.0 and Excel.

Results:

One hundred subjects aged 60 and above were interviewed, out of which 72.3% were living in the joint family system (JFS), whereas 22.3% were living in a nuclear family system (NFS) and 5.4% people are living alone. Out of 130 elderly 51.98% were women. A majority of the population fell in the age range of 65-70 years, with the mean age being 68.7 years. 73.25% subjects in joint family system were married. Most of the males were found to be retired .61.23% in joint family system were unemployed whereas 56.09% subjects in nuclear family were unemployed.72.57% subjects in joint family system were depended on their children. Majority of the respondent in joint family system were satisfied with their family structure and 65.4% elderly commented that modernization has destroyed the family structure and family value. A decline in the proportion of JFS was seen in the subsequent generation and majority of the elderly perceived that family system has a significant impact on health. The pattern of healthcare utilization was not good. For the chronic ailment they were using Govt. hospital and for the entire normal ailment the elderly were using the clinic in their village.

CHAPTER- I

INTRODUCTION

Family is a group consisting of parents and children living together in a household and they are also depended on each other for living a good and healthy life. Health and well-being are the result of synergistic interactions among a variety of determinants. Family structure and composition are social determinants that may also affect health behaviours and outcomes. Health problems are supposed to be the major concern of a family as older people are more prone to suffer from ill health than younger age group. So, family plays an important role to care the elderly population

In Indian society, we can find three types of family- single, nuclear and joint. Nuclear family is consisting of a pair of adults and their children whereas joint family is consist of parents, their children, and the children spouses and the off springs.

The Indian family traditionally has been viewed as a close-knit social unit from which its members derived support, security, and a means for meeting their needs. The Indian elderly were cared for by their families; moreover, respect for the aged was considered a virtue in the Indian tradition. The aged represented life experience, knowledge, authority, and status. In today's world, however, the emphasis on individualism, nuclear family autonomy in an urban-industrial milieu and economic discrimination against minorities often create pressures on the children of Indian immigrants that lead to disregard for their elderly parents. In recent years, as the number of elderly has increased and the influence of cultural norms and traditional structures has diminished, the problems of older Indians have multiplied. Inadequate income reduced physical capabilities, and social isolation often makes old age a period of degeneration and suffering. Of particular importance is the health care of the poor and minority elderly. The Indian elderly especially are confronted with poverty, isolation, racial discrimination, poor housing, and poor health.

1.1 Socio-demographic condition of Elderly in India and Odisha

India is the second most populous country of the world. The combination of high fertility and declining mortality has resulted in large and rapid increase in population.

The continuing population growth in India during the past 50 years has been accompanied by a marked increase in the number of the aged. According to the decennial censuses, the number of aged has increased from about 19.8 million in 1951 and to 56.7 million in 1991 or by 189 percent over the 40 year period. Their share in the total population has increased from 5.5 to 6.8 percent, or by 24 percent. If the proportion of the aged had not risen, the number of the aged would have grown to 46.5 million or 137 percent. In effect, nearly 72 percent of the increase in the number of the aged has to be attributed to population growth, whereas the balance 28 percent has been due to the ageing of the population.

According to the population projections for the Ninth Plan, the number of aged 60 and above will rise from 54.5 million in 1991 and 62.3 million in 1996 to 70.6 million in 2001, 81.8 million in 2006, 95.9 million in 2011 and 113.0 million in 2016. While the total population will increase by 49 percent from 846.2 million in 1991 to 1263.5 million in 2016, the number of the aged will rise by 107 percent over 25 year period. The share of the aged in the total population will rise to 8.9 percent (from 6.4 percent in 1991 according to the smoothed age distribution). Unlike during 1951 – 1991, the contribution of the changing age structure to the growth in the number of the aged will be a major factor, accounting for 55 percent of the projected increase.

The number of elderly population in Orissa is increasing very rapidly. The number of elderly increased from 22.81 lakhs in 1991 to 30.39 lakh in 2001. The concentration of aged in terms of its share to total population is 8.26 per cent in the state. A majority of the elderly of the state (88 per cent) live in rural areas. As per the Population Projections, the number of elderly in Orissa is likely to be around 62.69 lakh in 2026; i.e., an increase of more than two times in a span of 25 years, and the share of the elderly is expected to be 13.8 per cent of the total population (Census of India 2001, 2006). An important way of looking at the burden of the elderly for any society is the old-age dependency ratio. The old age dependency ratio has increased marginally from about 12.74 per cent in 1991 to 14.14 percent in 2001, being somewhat higher for females than for the males. Any increase in the old age dependency ratio implies that an increasing number of the elderly, generally with altered physiological, psychological or sometimes even professional capabilities and with reduced work

participation rates have to depend heavily on the working population in the age-group for support. This could have serious implications for the well-being of the elderly at household level (GoI, 2002).

The elderly in a poverty-ridden state like Orissa are more vulnerable. To understand the nuances, an examination of some demographic and socio-economic indicators of older persons–in terms of their living arrangement, extent of economic independence, economic service-providers and health condition is required. However, NSSO's two different round surveys carried out during 1995-96 (NSS 52nd round) and 2004 (NSS 60th round) give valuable information about the nature and dimensions of the conditions of and socio-economic problems faced by the aged in the state. The results of these two surveys in addition to that of the results of the last two censuses have been used in subsequent analysis and wherever possible, inferences have been drawn to assess the changes over this period.

Living Arrangement

The term 'living arrangement' is used to refer to one's household structure (Palloni, 2001). Irudaya Rajan et al. (1995) explains living arrangements in terms of the type of family in which the elderly live, the headship they enjoy, the place they stay in and the people they stay with. The two rounds of surveys of NSSO give information on living arrangements of the elderly. The 2004 results for Orissa showed that about 50 per cent of the aged were living with their spouses and other members, and another 30 per cent were living without their spouses but with their children, while about three per cent were living with other relations and non-relations. Nevertheless, about 12 per cent were living with their spouses only while about 3 per cent were still living alone. Moreover, the living arrangement of the aged has changed to some extent since 1995-96. A comparison of data between these two survey periods (1995-96 and 2004) reveals the following:

1. The proportion of the aged who lived with their spouses only had gone up significantly from 8 to 12 per cent in urban areas and remained the same in rural areas.

2. The proportion of the aged who lived with their children only had however, decreased from an already low of 31 per cent to 26 per cent in urban areas. On the other hand, the proportion of the aged who lived with other relations and non-relations had increased from 3 per cent to 5 per cent in urban areas. This probably reflects the further weakening of the extended family system in the state as evidenced in other part of the country.

Economic Independence

The living arrangement depicts how the well-being of the aged is ensured in the family in our society. Similarly, the economic independence reveals the associated problem of day-to-day maintenance of livelihood of the elderly. The distribution of aged persons according to the state of economic independence for the state as per NSSO survey(NSS 60th round for the year 2004) shows that as high as 70 per cent of the aged had to depend on others for their day-to-day maintenance. The estimated number of aged dependent was found to be around 20 lakh in the state. Compared to 1995-96, the results of the NSS for the year 2004 indicate the following:

1. The incidence of economic independence had decreased among elderly in rural areas.

2. The aged who had to depend on others (for their day-to-day maintenance) fully has increased both in rural and urban areas.

Economic Support-Providers

As has been observed above, a large proportion of the elderly are economically dependent on others for their livelihood. It is, therefore, pertinent to know who is providing economic support to the elderly. It is seen that of the economically dependent aged, a majority (about 78 per cent) had to depend on their children and a sizable proportion (13 per cent) on their spouses. Only 3 per cent were supported by their grandchildren and the rest (6 per cent) had to depend on 'others', including non-relations. In the inter survey period, the distribution of the (economically dependent) aged changed in respect of the category of persons supporting them. The major findings:

1. The proportion of the aged males and females in rural areas depending on their children for economic support had decreased from 81 per cent in 1995-96 to 76 per cent in 2004.

2. Those depending on their spouse and on 'others', including non-relations, increased (from 11 per cent and 3.6 per cent in 1995-96 to 14 per cent and 5.7 per cent in 2004 on their spouse and on 'others' respectively) significantly in rural areas.

1.2 The impact of modernisation on family structure and health of the elderly

India is a country with ancient culture and tradition where elderly enjoyed a respectful position in a society. The traditional norms and values of Indian society laid stress on showing respect and providing care of elderly. Joint family with common land holding were abundant in rural areas. In past years joint families were not even norm, they were just the things they were. Parents, their children, their children's spouse, grand children all living together in harmony. The man worked and the women of the family handled home. So, the elder people care was never a problem. But as time passes its face is changing. The advent of globalisation, modernisation, industrialisation, occupational differences, education and growth of individual philosophy has eroded the traditional value that vested authority with the elderly. Now the extended family system has been replaced by nuclear family system. It leads to the gradual marginalisation of elderly in decision making process in an average family and a breakdown of family as a traditional social unit has brought problems of the elderly in the society. The family, commonly the joint family type and social network provided an appropriate environment in which the elderly spent their lives. Due to modernisation the social connection is decreasing. The respect, power and authority that the older people used to enjoy in rural joint families is being gradually reduced in India in recent time. Due to industrialisation people are migrating to industrial areas for employment. As a result their old parents are not getting proper family support and care. They feel lonely and this loneliness leads to many diseases and psychological problems among elderly.

1.3 Family structure and health care of the elderly

Health problems are the major concern of a society as older people are more prone to suffer from ill health than younger age groups. It is often claimed that ageing is accompanied by multiple illnesses and physical ailments. Besides physical illnesses, the aged are more likely to be victims of poor mental health, which arises from senility, neurosis and extent of life satisfaction.

As people get older their family structure changes as children leaves home and spouse die. Also, as their friends die, the network of older person shrinks. Due to industrialisation and modernisation family structure is changing more people are living without their children. So, the intimate connection changes with age. These changes affect the health of the elderly. Social connections come from a variety of factors-family, friends, shared living spaces, interaction with neighbours and participation in community or religious organisation. But as

they get older social connection reduces and social isolation increased. Married couples exchange their emotions, information about their health and get or provide emotional support. Loss of parents or spouse is also a loss of psychological and social support and access to informal healthcare. But illness can also drive social isolation. As their health deteriorates, older people no longer tend to be at the centre of a network of friends and acquaintances but more often are on the periphery of social activities.

In relation to population aging, the family itself undergoes a transformation as a result of demographic changes which are the part of the aging process. The family also serves as a protection against ill-health. In India, the family is the traditional social institution for the care of the elderly and is expected to continue the role of care giver as the principle source of support security in old age. Generally the familial system of care and support for the elderly includes emotional, social, and economic and health support in old age. The elderly people are mostly dependent in Indian context. The large number of families who live under the poverty line, for instance, cannot possibly provide the care and support for the elderly that are traditionally expected to (Chang. 1994).

1.4 Healthcare system of India

Healthcare system in India comprised of Gov. Sector and Private Sector and more dominant in private sector. The spending on the health is very low and central govt spent 1.3% of its budget on health. Private medical sector contributes 83% and the Govt. 17% of India live. Some progress has been made in the quality and quantity of healthcare services in India but much emphasis on maternal and child health programmes. The elderly people are inadequately covered by the health, economic security. Old people’s health status in India is impacted due to lack of health facilities in rural areas. Large number of older people lives under poverty resulting into their poor health. Geriatric health care gets little attention in India.

CHAPTER- II

2.1 REVIEW OF LITERATURE

Choeichom, S.(2005) This thesis focuses on pattern of sickness and health service utilization by the elderly including related factors such as age, sex, marital status etc.. The objective of the study is to analyse the elderly health service utilization and the analyse major reasons and participation in decision making in relation to the health service utilization. The study also aims at to study the characteristics of demographic, economic, society and sickness of elders in Kanchanaburi province. The results of the study were-62.4% of the elders decided of their health service utilization by themselves. 33.6% of them had their joint decision making with others and least of them did not have any participation in the decision making.

Turagabeci, Nakamura, Kizuki & Takano, (2007). The main of the study was to determine the effect of family structure on health related quality of life and psychological health measures and to determine the association between family structure and health. It also examines how good family supports improve quality of health outcomes. The result of the study is good family support acts as a protection against harmful influence of living in small family that will lead to improve quality of health outcomes. This study also finds that compared to extended families, elderly people living in small families are much affected by hypertension and poor mental health. This study explains there is a strong association between family structure and health. Living in multigenerational family system should be viewed not only as a social obligation but also as a useful form of social support to better heath related quality of life.

Hussain & Ghosh (2011).This article examined the health status of elderly in India and analysed their relationship with the living arrangements and extent of economic dependence. This study has used 1995-1996 and 2006 unit level data of NSSO, India “on morbidity, healthcare and condition of the aged”. It provides changes in the demographic and socio-economic condition in the self-perceived health status of the elderly population of India over a decade. An important result of this study is that perceived health status of the elderly has declined due to decrease in family support.

Ayudhya (1991). Stated that the population in agricultural sector had lowest income whereas the government officers had stronger income security and benefited from several security systems, so they were not much affected by the economic crisis and their choice of health services was consistent. But in business sector, most of the people were small entrepreneurs, so they could not endure higher cost and fewer customers during the crisis. This resulted in the change in health service utilization into more of self-care.

Shanas (2003) Family plays a crucial role in healthcare of the elderly. The paper examines on two aspects of the family as a social support system: family care forthe elderly in time of illness and family visiting patterns. The data come from a 1975 national probabilitysurvey of non-institutionalized persons, 65 years of age and older. The immediate family of the oldperson is the major social support in time of illness and the extended family of the old person, children,siblings and other relatives, is the major tie of the elderly to the community**.**

Brown, Pagan & Oreggia (2002). The health care system in Mexico is characterized by a clear differentiation between public and private services. Health care entities in the public system are financed out of general taxation, through funds allocated by central and state governments and through taxation on personal labour income in the formal sector. For these employees, institutions such as the Mexican Institute for Social Security , the Social Security Institute for Government Workers and Petróleos Mexicans give health-related services, while the general public access services primarily through the National Health Secretariat and IMSS-Solidarity systems, paying a small fee.

This study analyses whether there is equity in health care utilization in Mexico. Adequate health care has been identified as necessary to achieving equity in economic/social opportunities. Using data from the Study on Mexican Health and Attitudes towards the Recovery Process 2000, this study estimate a two-part negative binomial hurdle model to evaluate health care utilization. This article finds evidence of inequality in health care utilization, after controlling for need and family structure factors. There are income-related differences in utilization related to the first visit to a physician. There are also considerable differences by region and by employment, insurance and financial status. There is also income-related inequality in the first visit to a specialist but not in the number of days hospitalized.

Jamuna.D. (2000). In the coming decades, there will be a rapid increase in the number of elderly in India; with their rate of increase being faster than that of the total population.it creates challenge for the country to manage this huge elderly population, given its poor resources and standard of living. This article briefly discusses some of issues to deal with the challenge with regard to work status, dependency ratio, living arrangements, gender ageing, health and disability status, family and kinship relationships and availability of social security provisions for the elderly. Policy that would cover all sections of the population, the nonexistence, as yet, of any concrete steps on the part of the state to tackle the complicated problems of the elderly, the increasing stress and strains on the primary caregiver, the fast pace of societal change that is affecting traditional caregiving mechanisms for the elderly, as well as the need for a dynamic action plan to utilize the resources of the elderly and enhance their social status are discussed.

Allin, Masseria & Mossialos (2006).

The study attempted to examine the extent of income-related inequity in the use of hospitals, inpatient, outpatient and dental services among individuals aged 65 and over in the United Kingdom between 1997 and 2003 using a panel analysis of data from the British Household Panel Survey. The results indicate that individuals on a lower income are significantly less likely to visit a hospital, specialist or dentist than the better-off, although they have significantly greater need. However, horizontal inequity is found with utilization favouring those on a higher income for all service areas, but not significantly in hospital care.

Itrat, Taqui, Qazi, & Qidwai (2007). This study attempted to know the present status of family systems in Pakistan, changes they are undergoing and implications of such trends on health of the elderly population. Verbal informed consent was taken from the participants. The questions included demographic profile, satisfaction with current family system, opinions about changing trends of family systems, and their implications on health. Four hundred subjects aged 65 and above were interviewed, out of which 226 (56.5%) were living in the joint family system , whereas 174 (43.5%) were living in a nuclear family system . 326 (81.5%) respondents said that the trend in family systems in Pakistan was changing .A decline in the proportion of joint family system was seen with subsequent generations. 340 (85%) subjects said that a family system has a significant impact on health care.

Chang, TP., (1992) The proportion of elderly population is increasing. Asia will have the majority of the world's population and is a region where attention should be focused. Modernisation has affected the family structure but traditional family forms are the basic institution around which societies organise themselves. Changes in the family structure would, therefore, affect the care and support of the elderly

Bos, AM., (2007). This study attempts to study the current demographic trends point to the need for understanding the health challenges facing the elderly in Latin America today. This study assessed whether health care provider choice and household income impact utilization and health among the elderly in Brazil. Brazil's public health system does not adequately provide for the health needs of the elderly population. Policy recommendations include further investments in the public health care infrastructure, full implementation of the National Plan for Elderly Health, and developing new programs for effective geriatric consultations at the primary care level.

2.2 DEFINATION OF KEY TERMS

The following are some of the key words of the study:

- Ageing: it is the set of process which contribute to health detoriation and ultimately to death with the passage of time.
- Family: it is the social group consisting of one or more parents and children.
- Health: The state of free from illness.
- Healthcare: the maintenance of and improvement of physical and mental health.
- Elderly people: Though there is not a particular definition of elderly people but in India elderly people are defined as persons in age group of 60 and over. The age limit is partly decided by current norms about the retirement applicable in formal or non-formal organisation sector.
- Social net- work: the web of social relationship that surrounded on individual and characteristics of those ties.
- Nuclear family: Nuclear family is consisting of a pair of adults and their children.
- Joint Family: Joint Family is consisting of parents, their children, and the children spouses and the off springs.

2.3. RATIONALE OF THE STUDY

India is the country with the second highest population of the elderly, aged 60 and above, next only to China. The combination of high fertility and declining mortality has resulted in large and rapid increase in population. Further the sharp decline in mortality rate is the main cause for the increasing in elderly population. So, in the forthcoming decades there will be tremendous increase in number of elderly in India, with their rate of increase being faster than that of the total population. The 2001 census report has shown that the elderly population of India was 77 million while in 2001 census it was 53 million. In 1981 census the elderly population was 43 million.

Owing to its peculiar positioning in the demographic transition, the age structure of the country reveals that the number of elderly population is increasing very rapidly in recent years. According to an estimate, India will be having the highest aged population in the world by 2025.

There are literatures that points out that in spite of the growing numbers of the aged in the country; institutional social safety nets for the elderly are extremely inadequate. In a social milieu where family networks play the major source of psycho-social support and deep rooted cultural norms and perception regarding the family, although apparently dwindling in near past, the role of family as the important source of support for the elderly assumes greater significance. Thus effective family support is a key component of the overall well-being of the elderly. Following the traditional living arrangement prevalent in rural India, co-residence of the aged members of the family with their children is common. Some past research presents conflicting theories about the effect of co-residence with children on the l well-being of the elderly. While some told that governed largely by customary practice, residing together with offspring, particularly sons, positively influence the ‘perceived’ well-being of the elderly, others are of the opinion that it is the ‘quality of interaction’ and not co-residence with children self-awareness determines satisfaction and well-being of the elderly. The viewpoint also asserts that problems—social, economic, etc. associated with co-residence can negatively impact psychological and emotional well-being of the aged.

The impact of industrialisation and modernisation affects the family structure (Jamuna, D. 2000) and it also destroyed the traditional family system. Migration of the young people from their native place affects the elderly care and the intimate connection change with the age.

Utilisation of healthcare services refers to the accessibility and affordability of the household, particularly the poor household in which the elderly lived. Utilisation of healthcare services saves unnecessary death among elderly. Some past researches have shown that people in rural India are more vulnerable to death by diseases because they are not utilizing the health care facilities. The reasons of not utilizing the healthcare facilities are unawareness, illiteracy, lack of facility available in their village. Rural areas lack healthcare services where 70% India live. Old people health status in India is impacted due to lack of health facilities in rural areas. Large numbers of older people live under poverty resulting into their poor health. Geriatric health care gets little attention.

From this viewpoint, this study aims to examine the pathways of how changing family structure affects the health of elderly and in particular impacts on familial support. Given the sublime importance of familial support system in developing settings like India in influencing overall well-being of the elderly, this study traces the dynamics of family support towards better understanding the factors constituting intra-family support systems for the elderly. It also aims to investigate the pattern of health service utilisation in Santoshpur village.

2.4 OBJECTIVES

- To know the present status of family system in odisha, changes they were undergoing and implication of such trend on health of the elderly population and to examine the perception of elderly regarding their family support.
- To examine the pattern of health and healthcare utilization among elderly.

CHAPTER-III

METHODOLOGY

Sample

The present study was carried out in Santoshpur village of Sundergarh district of Odisha. This village has three hamlets- Jaratoli, Pahartoli&Militoli. All the hamlet have the same socio-economic condition. This village have 225 household and the elderly living in all the household were taken into account. Therefore no specific sampling technique was employed.

Tools and Technique

Tools are the instruments though which the investigator collects data for the study. Though there are various tools to collect information, this study uses questionnaire and interview for the collection of information.

Procedure

The present study was based on primary data, and data was collected through well designed and structured questionnaire and interviews. The initial questionnaire was developed based on issues identified through literature search. A pilot study was carried out on 30 subjects to screen for potential problems in the questionnaire and to get an idea about responses to our open ended questions.

Interviews were conducted using open ended questions. The interviewers discussed the questionnaire before data collection to eliminate interviewer bias. Written Informed Consent was taken from subjects after they were explained the study. Assurance with regards to confidentiality was provided.

The questionnaire was divided into four parts. The first part comprised of the socio demographic characteristics such as age, sex, marital status, education, occupation etc.. This part of the questionnaire is very important for any survey because it gives various valuable information about the subjects the demographic characteristics are the most recent data about the population and commonly examined demographics about age, disabilities, mobility, home ownership, employment status and even location. Demographic trends describe the historical changed in demographics in a population over time. The second part covered the current family system of the subjects, their satisfaction with it and reasons for satisfaction or dissatisfaction. The trends in family systems and the subject's opinion on whether the trend they identified was good or bad and the subject's opinion on the impact of each family system

on health is also included in second part. This part also included the questions of the perception of elderly regarding their family support The third part dealt with cronic ailments, health care resources, particularly referral information, type of physician preferred, visits to physician, availability of medical facilities, and length of time waited for medical appointments. The fourth part includes both the inpatient and outpatient treatment and the subjects health care utilization. It covers the questions like source of preference to access the healthcare, no of times to visit the doctor for a particular ailment, no of days in staying in hospitals, the amount of expenses etc.

Data entry and analysis was done by using spss 15.0. Cross tab and frequency are used for analysis of the data. Data analysis was also done by using excel 2007.cross tabulation is a way to examine the relationship between 2 variable. To find out the relationship cross tab is used. For the analysis of the datas, tabular techniques was employed to work out the averages, ratios, and percentages for the data related to family structure, their socio demographic characteristics and health service utilizations.

CHAPTER-IV

ANALYSIS AND FINDINGS

My first objective is to know the present status of family system in odisha, changes they were undergoing and implication of such trend on heath of the elderly population and to examine the perception of elderly regarding their family support.

For the analysis of this objective the questionnaire is divided into five major parts. The first part is the socio demographic characteristics, the second part is to know the satisfaction of the elderly with their family structure, the third part is to know the perception of elderly on changing pattern of family structure and status of the elderly, the fifth part is the dependency and decision making on children on healthcare.

4.1. Socio-Demographic Profile of the Respondents

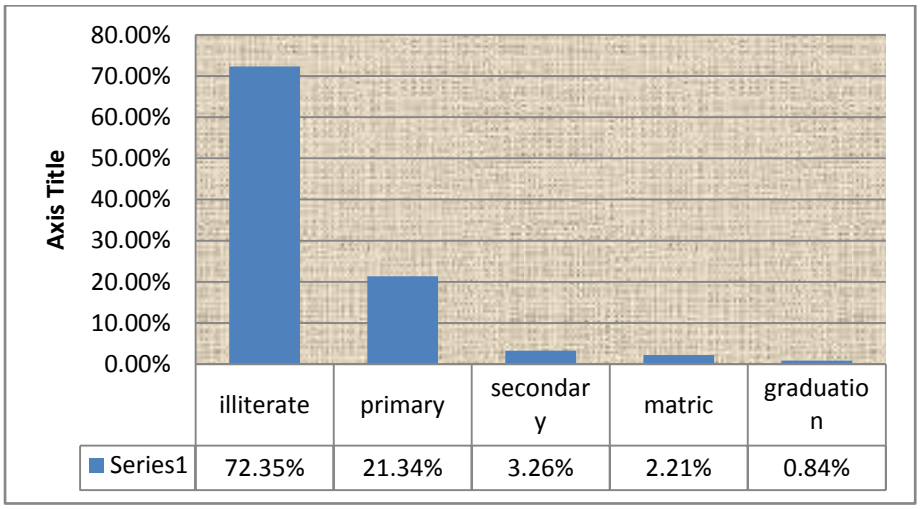
Table-1 shows the socio-demographic characteristic of elderly population. A total of 130 subjects aged 60 and above were surveyed. Out of 130 elderly 51.98% were women. A majority of the population fell in the age range of 65-70 years, with the mean age being 68.7 years. 73.25% subjects in joint family system were married.Most of the males were found to be retired .61.23% in joint family system were unemployed whereas 56.09% subjects in nuclear family were unemployed.72.57% subjects in joint family system were depended on their children and 14.2% people were depending on pension for their sustenance. Table- 1 shows the details of socio-demographic characteristic.

Table- 1

Sl no	**Parameter**	**Joint family**	**Nuclear family**	**Single**	**Total** (mean)
1	**Age**				
	Mean	68.4	69.4	68.3	68.7
2	**Sex**				
	Males	48.77%	41.77%	53.3%	47.94
	Females	51.23%	58.23%	46.5%	51.98
3	**Marital status**				
	Single				
	Married	8.23%	9.45%	25.23%	14.3
		73.25%	69.43%	23.43%	55.03
	Widowed/				
	Widower	15.3%	17.54%	43.89%	25.57
	Divorced				
		3.22%	3.58%	7.45%	4.75
4	**Education**				
	illiterate	72.35%	74.34%	78.68%	74.45
	Primary	21.34%	20.93%	18.23%	20.16
	Secondary	3.26%	3.4%	3.00%	3.22
	Matric	2.21%	0.45%	0.00	0.88
	Graduation	0.84%	0.88%	0.00	0.57
5	**Employment status**				
	Employed	23.21%	28.23%	35.23%	28.89
	Unemployed	61.23%	56.09%	53.67%	56.99
	Self-employed	2.45%	6.98%	6.32%	5.22
	Retired	13.11%	8.7%	4.78%	8.86
6	**Financial Support**				
	Children	72.57%	69.87%	2.1%	48.18
	Self	13.23%	12.98%	56.76%	27.65
	Pension	14.2%	17.15%	4.5%	11.95

Literacy plays an important role in health care utilization but majority of the elderly were illiterate.Majority of the subjects are illiterate (74.45) and only 2.21% subjects in joint family passed matriculation. The literacy level of elderly is given in figure-1.

Figure- 1 Literacy Level of Elderly People

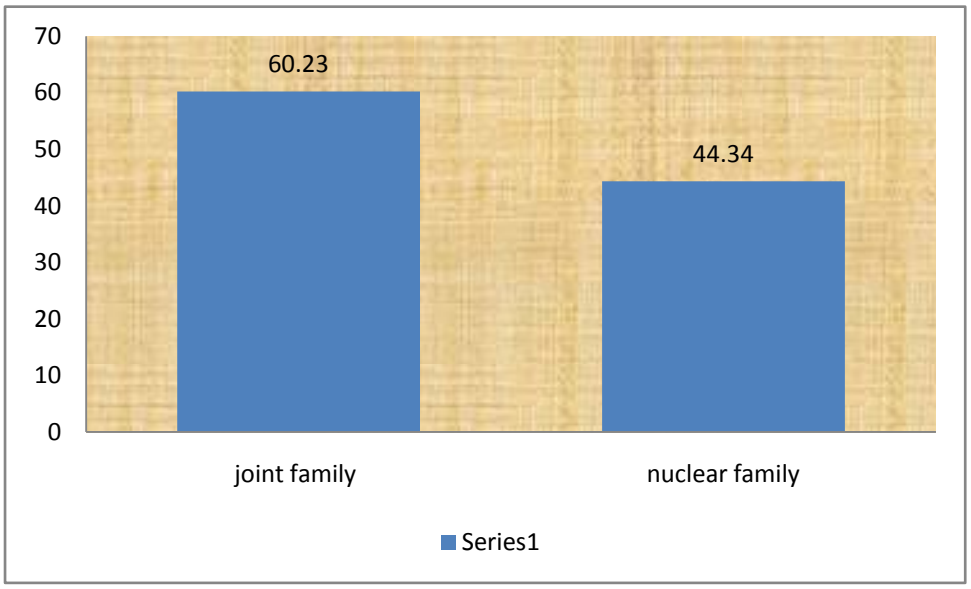


4.2 Responses of Subjects satisfaction with family structure

Table 2 lists the major differences among elderly with regards to JFS and NFS. Satisfaction with their current family system was expressed by 76.45% respondents. Only 2.34% of elderly were satisfied with their current family system in single family structure. The level of satisfaction was found to be more among people in the JFS group (60.23% vs.44.34 %) in NFS.

Figure-2

Responses of Subjects satisfaction with family structure



In the Joint family setting the major reason for satisfaction was given as general support in everyday life provided by the family members (62.89%). Out of those who expressed dissatisfaction with their joint family system, majority provided the reason to be frequent arguments between the family members (39.09%). The major reason for satisfaction among

those living in NFS was more Peace of mind (49.83%). Out of those who expressed dissatisfaction over their nuclear family system (15%), the major reason for this dissatisfaction was provided as less care and love. Table 2 also depicts about satisfaction about the current family structure.

Table-2. Responses of Subjects satisfaction with family structure

Reasons for satisfaction

Joint Family System	**Nuclear Family System**
a. General support: 62.89%	a. Peace of mind: 29.83%
b. Unity and feeling of love: 20.23%	b. Independence: 65.67%
c. Financial support: 17.4 %	c. Can live separately: 4.5%

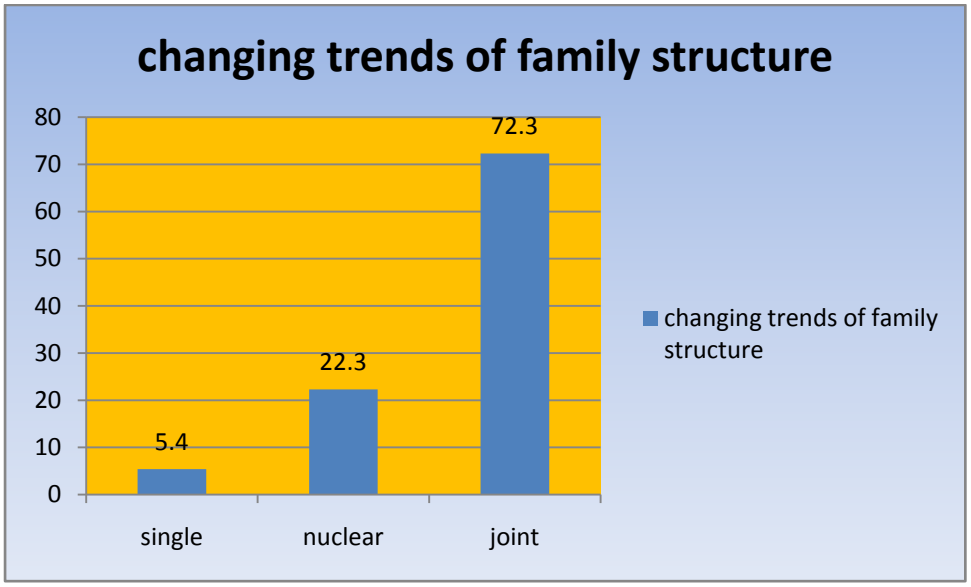
Reasons for dissatisfaction

Nuclear Family System	**Joint Family System**
a. boredom: 15.14	a. conflict in family: 46.09%
b. loneliness: 34.32%	b. less decision making power: 24.93
c. less care and love:50.54%	c. no peace of mind: 28.98%

4.3. Responses on Changing Pattern of Family Structure

For the assessment of trends in the family systems, it was observed over 3 generations. The percentage of people living in the joint family with each generation was falling (Generation 1 = 95%, Generation 2 = 81.5%, and Generation 3 = 72.3%). As regards the opinions on the trends, 70.25% elderly in nuclear family thought that the trend was changing and 56.34% elderly in joint family thought that it was a JFS to NFS trend. Upon inquiring whether a family system plays any role in health care, majority (85%) said that a family system plays a significant role in health care. JFS was the system plays a significant role in health care. JFS was the preferred family system in illness (78%) as well as emergencies (73.8%). Figure 3 depicts the changing pattern of family structure.

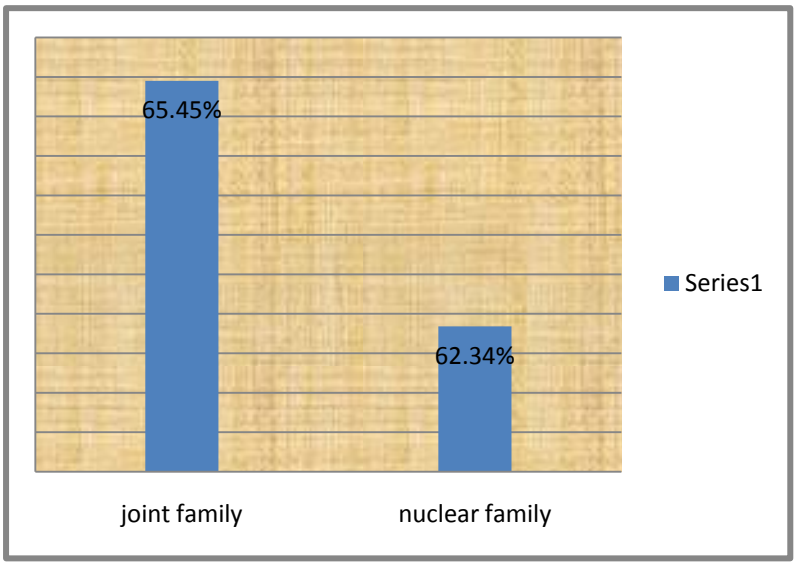
figure-3 JFS-NFS trend as perceived by the elderly



4.4. The perception of elderly on Impact of modernisation on family structure and status of elderly

Table- 4 depicts the perception elderly on the impact of modernisation on family structure and the status of elderly. It is interesting to find from table that the elderly person in Santoshpur village thinks that the present generation is not perceived the elderly as burden. 42.42% elderly people thought that due to financial hardship the present generation is giving less care and support to the elderly. 58.89% subjects in joint family think that modernisation is the main cause of the degradation of family structure. On the whole, people in all family system told that modernisation is the main cause of degradation of family structure and status of the elderly.

Figure- 4.Percentage of respondent who thought that modernization has decrease the family structure and role of elderly



The impact of modernisation has also seen in the Santoshpur village.65.45% of the elderly commented that modernisation has decreased the family structure and the status of elderly population. Some elderly people commented that the current generation people are not responsive to the elderly. They are not giving importance to the family value. Modernisation has destroyed the traditional family structure and the family value.

Majority of elderly 84 (64.6%) said that their family members are giving proper care and support to them while 64 (49.29%) elderly commented that they are satisfied with their family support. Family support includes also the financial support which is the important aspect of satisfaction. 70.23% people in joint family system said that old age people are getting proper care and support. They told that their parents are getting much care and respect they have better decision making role in family. With the passage of time their role has changed and their status has been decreased. They blemed modernisation and industrialisation for the breaking of the family structure. 54.89% in joint family and 48.24% elderly in nuclear family system commented that modernisation is the main reason of breaking of family structure. 30.05 % elderly in the joint family system thinks that financial hardship is the also a reason that the present generation is not able to fulfil their parents needs and desires. In Santoshpur village majority of people are working as industrial nonformal

worker or as agricultural labourer. Their financial condition is not good. So, they are not able to give proper care to the elderly parents due to financial hardship.

Figure-5Percentage of respondent, who thought that due to financial hardship the present generation, was giving less care to the elderly people

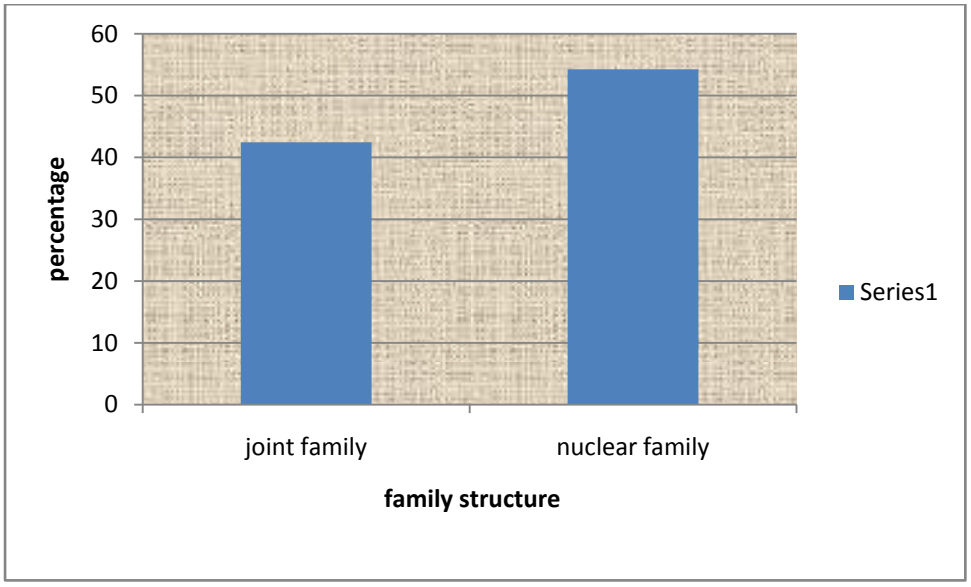


Table- 3

The perception of elderly on Impact of modernisation on family structure, status of elderly and family support

- **Percentage of respondent in the following family system, who thought that modernisation has decreased the family value and status of elderly**

  Joint family system: 65.45%

  Nuclear family system: 62.34%

  Single person: 65.09%

- **Percentage of respondent in the following family system, who thought that old age people are getting much care and respect in previous time in comparison to present modern days**

  Joint family system: 70.23%

  Nuclear family system: 80.23%

  Single person: 78.76%

- **Percentage of respondent in the following family system, who thought that modernisation is the main reason of breaking of family structure**

  Joint family system: 54.89%

  Nuclear family system: 48.24%

  Single person: 60.90%

- **Percentage of respondent in the following family system, who thought that present generation thinks elderly as burden.**

  Joint family system: 30.05%

  Nuclear family system: 23.24%

  Single person: 27.90%

- **Percentage of respondent in the following family system, who thought that due to financial hardship the present generation, was giving less care to the elderly people**

  Joint family system: 42.23%

  Nuclear family system: 54.24%

  Single person: 39.8%

4.5. Dependency and decision making of elderly on healthcare

Dependency and decision making power of the aged is decreasing now a days. 84.14% subjects are living with sons. The elderly of Santoshpur village love to stay with sons and love to live in joint family. 82.2% elderly in Santoshpur live with their sons while 9% people live with their daughters because of several reasons. 76% elderly in joint family told that their decision making role has changed after they grow old and 67% elderly who lived alone thinks that their role has changed after they grow old. A majority of the elderly (m=51.03) said their childrens generally take decision regarding to go to the hospital when they were seek. 61.27 and 62.13% elderly people are depended on their children for hospital expenses respectively in joint family and nuclear family. The following data reveals that the aged person in Santoshpur village depended on children for financial support for hospital expenses; prefer to live with sons and majority of the aged think that children are the main support of parents in old age.

Table -4 Dependency and decision making of elderly on healthcare

- **Percentage of respondent in the following family system, who thought that their role as a decision maker change after they grow old.**

  Joint family: 76%

  Nuclear family: 69.90%

  Single person: 56%

- **Who takes decision to go to hospital, when you are seek?**

  Joint family:

  Self: 32%

  Children:62. 45%

  Others: 5.55%

  Nuclear family:

  Self: 23.2%

  Children: 75.32%

  Others: 1.48%

  Single person

  Self: 73.2%

  Children: 15.32%

  Others: 11.48%

  Who gives money for the hospital expenses ?

  Joint family:

  Self: 21.23%

  Children: 62.13%

  Others: 16.64%

  Nuclear family:

  Self: 32.42%

  Children: 67.21%

  Others: 0.37%

  Single person

  Self: 72.2%

  Children: 19.32%

  Others:8.48%

Percentage of respondent in the following family system, who thought that children are the main support of parents during old age.

Joint family: 89%

Nuclear family: 81%

Single person: 68%

4.6 The second objective of the present study is concerned with the pattern of the pattern of healthcare utilisation among the elderly. Here the elderly population were asked questions related to their health and diseases status. The following table represents the percentage of ailments the elderly are suffering from and the source of treatment as well as financial support received.

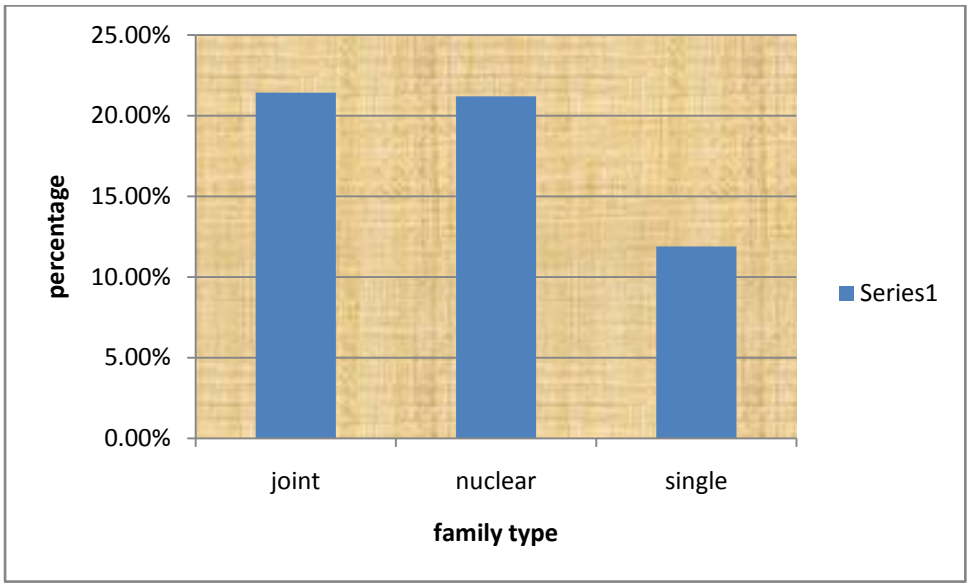
Table -5 Percentages of respondents who suffered from chronic ailments in the following family structure and their healthcare utilization

Chronic Ailments	Joint Family	Nuclear Family	Single Family	Source of treatment	Financial support from:
Arthritis	4.32%	4.56%	5.43%	Govt. hospital: 65% Pvt.hospital:2.5% Clinic: 32.50%	Children:72.8% Self:23.34% Others: 3.86%
Diabetes	7.50%	4.43%	5.23%	Govt. hospital:65.87% Pvt.hospital: 25.43% Clinic:8.70%	Children:67.8% Self:28.23% Others: 3.97%
Asthma	21.43%	21.20%	11.89%	Govt. hospital: 78.21% Pvt.hospital:12.24% Clinic:9.55%	Children:72.23% Self: 13.87% Others: 13.9%
High blood Pressure	10.67%	11.67%	6.77%	Govt. hospital:65.98% Pvt.hospital:18.98% Clinic:15.04%	Children:72.86% Self:20.43% Others: 6.71
Cancer	2.1%	1%	Na	Govt. hospital:64.13% Pvt.hospital: 32.34% Clinic: 3.53%	Children:98.90% Self:0.00 Others:1.10%
Cataract	4.21%	4.78%	2.32%	Govt. hospital: 81.23% Pvt.hospital: 15.23% Clinic:3.45%	Children: 50.53% Self:12.98% Others:36.49%
Dementia	0.00	0.00	0.00	Govt. hospital: 0.00 Pvt.hospital: 0.00 Clinic:0.00	Children:0.00 Self:0.00 Others:0.00

Tb	12.23%	6.98%	9.13%	Govt. hospital: 78.97% Pvt.hospital: 12.67% Clinic:8.33%	Children:67.87% Self:12.09% Others:20.04%

Table- 5 depicts the chronic ailments of aged in the Santoshpur village. It is interesting to see that dementia disease is not found in a single case out of 130 subjects. It may be due to their strong bond with the family members or they are not aware about this ailment. 9.47% of aged was suffering from TB .The prevalence of TB found more among male than females.it is because of the males were working in the rolling meal. The industrial dust is the main reason of TB among the males. it has seen that majority of the elderly were suffering from asthma.Majority of people prefer to visit to Govt hospital for the chronic ailments. The above table also depicts that subjects are mostly depended on children for medical expenpenses.. The following figure shows that proportion of people suffering from Asthma.

Figure: 6 The proportion of patients suffering from Asthma.

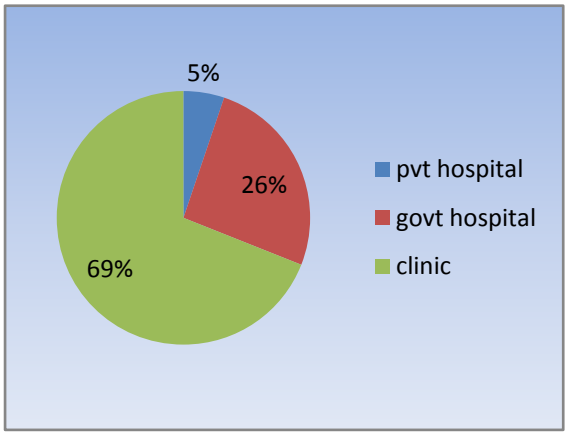


4.7. Healthcare Utilization: Out patient

This study has taken the ailments of the subjects within the six month (july-december) since the time of data collection. It has marked that majority (68.97%) of the aged preferred to go to a private clinic located in militoli hamlet. The prevalence of dysentery and malaria is very high among the elderly.75.09% aged were suffered from dysentery. Out of 130 subjects, most of them depended on their children for hospital visit. It is interesting to see that the

subjects prefer to visit the govt.hospital in chronic diseases while in the normal ailments they prefer to visit clinic.

Figure: 7 Percentage of respondent who prefer to visit clinic, pvt.hospital, govthospita

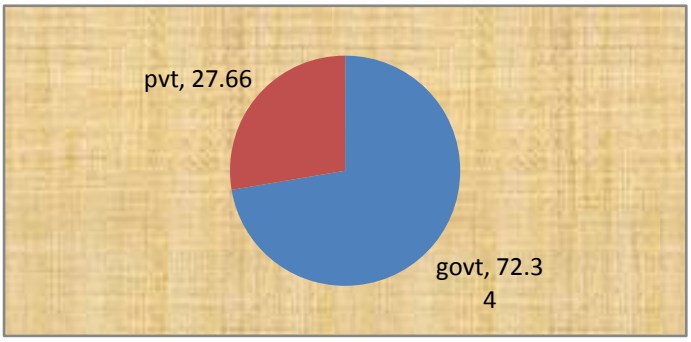


The main reason of visiting clinic of the elderly was the hospital was 16 km away from that village. Some people (45.23%) commented that the doctor is not available most of the time. some subjects were also dissatisfied of the treatment of doctors. Long waiting hour is the main reason of not visiting the Govt doctors.

4.8. Healthcare utilization: Inpatient

The proportion of hospitalisation is very less among the elderly (4.5%) and majority of them hospitalised for the operation of cataract in govt hospital. Majority (68%) of the elderly commented that their family members give support at the time of hospitalisation.1.25% elderly were hospitalised for the chronic ailments and they prefer govt hospital for the hospitalisation. Financial problem is the main reason that they were not able to take any type of treatment. People go to govt hospital for fewer expenses because majority of them are poor and the village clinic has not proper facility for the inpatient treatment and they can't visit the pvt. Hospital due to poor economic condition.so, in severe illness they only prefer to Govt hospital.72.34% visits the govt hospital for inpatient treatment.

Figure-8. Inpatient source of treatment



CHAPTER-V

DISCUSSION AND CONCLUSION

5.1 Discussion

It has been seen that the traditional joint family system is declining and that it is being replaced by nuclear family system in all over the world. To examine this, we assessed the opinions from the respondents about whether there are changing trends, and if yes, in which direction. Furthermore, three subsequent generations of the subjects were assessed, and opinions about how this changing trend is influencing the family systems were taken. From the population sample, it was observed that of late, the number of people having a joint family system is falling, with the current generation showing a slow fall sharper fall than the previous one.

A majority of elderly in joint family system were depended on children for hospital expenses in joint family while the aged who live alone take own decision regarding hospital expenses. This is because of the elderly in joint family are depended on children for financial support. So they think that their role as a decision maker changed as they grow old and this is probably the main reason that majority of the elderly think that children are the main support of parents in old age.

A large percentage of respondents living thought the family system trend has changed over the last few years and that the change was towards the nuclear family system. Considerable proportions observed this change to be bad, with a significantly higher proportion in the subjects coming from a joint family. About half of the subjects representing nuclear family system thought that the nucleation of family systems was a good change. Important issues for the elderly are specific health services which are lacking and most services are hospital oriented rather than home based. Nursing facilities are highly expensive. All these factors indicate a skewed opinion of the elderly towards the role of a family system as regards their health needs. Additionally a great majority of respondents confirmed that in both chronic and acute forms of illnesses as well as emergencies, a joint family system was suited better to cope with such an eventuality. Reasons noted for these responses indicate that social, more than any other form of support seems to be the primary reason why joint family systems are preferred by the elderly to cater to their health needs.

Inpatient treatment is a type of treatment in which a patient is provided with 24 hour care at live in facility. One important difference in inpatient treatment when compared to outpatient treatment is the amount of medical attention received by a patient.

Santoshpur village is a tribal dominated village which is 16 km away from Bisra block. In this village there is no Govt.hospital. There is a private clinic in Militoli hamlet. There is a sub-centre in Militoli hamlet but it is closed all the time. Anganwadi provide some medicine but medicines are not available all the time. So, people in this village go to clinic which is in their village and the doctor is available all the time. The fee of the doctor is very less. So, they don't prefer to go to Govt medical which is 16 km away from the village. Some aged person also commented that govt doctors are absent most of the time and medicines are not also given to them in free of cost. They also don't like to stand for long hours to meet the doctors. So, they prefer to go to clinic.

For the serious and chronic ailments the elderly go to Govt hospital. Some aged person also told that they want to take treatment from Pvt.hospital but financial hardship compels them to take treatment from govt. hospital. Another reason is that in majority of cases children took decision on the healthcare matters. The proportion of malaria and dysentery is very high in Militoli hamlet because majority of them use the river water for their daily use. Majority of the women in Jaratoli hamlet were not aware about the sub-centre in the village and financial problem is also a major cause that they are not going to hospital.

5.2 Conclusion

From the findings, it can be concluded thatthe traditional family structure is still continuing in Santoshpur village (72.3%) though it has seen that joint family system is slowly decreasing. Ninety percent people told that family system affects the health of elderly. Change is occurring in the family systems, with most people shifting from a joint family to a nuclear family setting, despite the preference for the joint family. Other interrelated factors that influenced the shift towards NFS were size of average households, the socio-economic status of the family, physical and psychological health of household members and the influence of media over the masses.

Healthcare utilization pattern was not good of 130 subjects, majority of women were not aware about the hospital facilities. Hospital was not there in the village and it was 16 km away from village. So, the elderly faces a lot of problem to access to medical service.

5.2 Future Directions

- This study only examines the changes of family structure due to modernisation and industrialisation. It has not covered the other factors which are the major reasons of changes in family structure. Further studies would need to be conducted to measure the contribution of each factor towards the shift from JFS to NFS. This study was confined to a rural village in Sundergarh district of Orissa. Thus the results of the study are applicable to similar kind of situation analysis. if a researcher do it in urban area and in macro level the result would be different.
- The present study would be a better study if it would have been taken in following ways.
- It will be more improved and perfect if the investigator will take more sample units. This study only has only taken 130 samples. The study will be more satisfactory if the investigator will take the study in the macro level.
- If more and perfect statistical technique for analysis and interpretation of data will be applied, then it would be better one.

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ROLE OF FAMILY IN HEALTH AND HEALTHCARE UTILIZATION.

APPENDIX-1

SOCIO-DEMOGRAPHIC CHARACTERISTICS

Sl.no	Questions	Codings	Skip to
1	Sex of the respondent -	Female…….1 Male……2	
2	How old are you?		
3	What is your weight?		
4	What is your height in ft?		
5	How many years of school, have you completed?	No formal education….1 Primary……2 Secondary…….3 Matric……4 Graduation……5 Above graduation…….6	
7	What is your current main occupation?	1.cultivator 2.govt job 3.private job 4.industrial non formal worker 5.agricultural worker 6.business 7.not working 8.other	
8	At which age did you start paid work?		
9	At which age did you stop paid work?		
10	What is the main reason behind are not working now/ unemployment?	Housewife…….1 Cant get a job ……2 Health problems…..3 Functionally disabled …4 Do not have economic need….5 Do not able to work…….6 Retired……7	
11	Do you want to work now?	Yes----------1 No----------2	

12	If yes, then why?	Economic need……1 Enjoying my work…….2	
13	If no, then why?	Children are supporting……1 Spouse is supporting…….2 Relative are supporting…….4 Health related problems……5 Functionaly disabled……6 Getting pension……..7	

APPENDIX-2

FAMILY STRUCTURE-I

Q 1	What type of family do you have?	Single……1 Nuclear…….2 Joint…….3	
Q 2	What is your current marital status?	Currently married……1 Separated…….2 Widowed……..3 Divorced ……..4	
Q 3	Are you living with your spouse now?	Yes……..1→ No ……2	Go to q no 5
Q4	Where is spouse living?	Living with sons With daughters With relatives Other (specify…..)	
Q 5	How many childrens do you have?	Son Daughter	
Q 6	How many children are staying/living with you?	Son Daughter	Go to q no8
Q 7	How many children are not residing with you?	Son Daughter	
Q 8	If children are away from you how often do they visit you?	Regularly ……..1 Sometimes…….2 Rarely……3 Never …….4	
Q 9	With whom are you staying?	Living alone…..1 With children…….2	
Q 10	Do you have a separate room for yourself?	Yes……..1 No ……2	
Q 11	If no where do you sleep?	With childrens……1 Verenda……..2 Kitchen ……..3 Others ……4	
Q 12	What is your preferred living arrangement?	With sons….1 With daughters…..2 With relatives Other (specify….)	

Satisfaction with family structure

Sl no.		
Q 1	What type of family structure you prefered most?	Joint….1 Nuclear...2 Joint …..3
Q 2	Why do you prefer joint family?	General support….1 Unity and feeling of love….2 Financial support…. 3
Q 3	Why do you prefer nuclear family?	Peace of mind….1 Independence…..2 Can live separately….3
Q 4	Why don't you like joint family?	Conflict in family….1 Less decision making power…2
Q 5	Why don't you like nuclear family?	Boredom….1 Loneliness….2 Less care and love….3
Q 6	Which type of family structure, do you think is good for healthcare?	Joint…1 Nuclear….2 Single….3
Q7	What is your preferred living arrangement?	With son….1 With daughter…..2 With family……3

Changing family structure

Q1	Do you think that the present family structure is changing?	Yes…..1 No……2
Q 2	If yes, then in which trend?	JFS- NFS……..1 NFS- JFS……..2
Q 3	Your forefathers were living in which family structure?	Generation- 1 Generation-2 Generation- 3

Impact of modernization on family structure

Q1	Do you think that modernization has decreased the family value and decreased the status of elderly?	Yes…..1 No……2
Q2	Provisionally the old age people are getting much care and respect in comparison to present modern day?	Yes…..1 No……2
Q3	Do you think modernization is the main reason of breaking of family structure?	Yes….1 No……2
Q4	Do you think that the present generation views elderly as burdens?	Yes….1 No…..2
Q5	The present generation is responsive to aged but due to financial hardship they were giving less care to the elderly people?	Yes…..1 No……2

Decision making and dependency on children on health care

Q1	With whom you are staying?	Son…..1 Daughter…..2 Others……3
Q2	Has a role as a decision maker changed after you grow older in family?	Improved…1 Declined….2 Changed…3
Q3	Who takes decision to go to hospital?	Self…1 Children….2 Others…..3
Q4	Who gives money for the hospital expenses?	Self….1 Children…2
Q5	Who took to you hospital?	Self…1 Children…2
Q6	Who takes care you, when you are seek?	Spouse…1 Children…2 Others…..3
Q7	Is your family member giving proper care and respect to you?	Yes….1 No….2
Q8	Do you think children are support of parents during old age?	Yes….1 No…..2

Perception of elderly about family support

Q1	Do you think that your family members are giving proper care and respect to you?	Yes……1 No……..2	
Q2	Are you satisfied with the care provided to you by your family members?	Yes……1 No……..2	
Q 3	Do you think that children are the main support of the parents at old age?	Yes……1 No……..2	
Q 4	In your opinion who should take care of the old parents?	Sons……1 Daughters….2 Both……3 Others (specify….)	
Q 5	Is your family giving proper support at the time of illness?	Yes 1 No-2	

APPENDIX-3

CHRONIC AILMENTS AND HEALTH SERVICES COVERAGE

Sl no	Has a doctor or nurse ever told you that you have any of the following ailments? Yes -1 No-2 Q NO-14		How long has it been? Less than one month-1 One month to six month-2 Six month to above-3 Don't know-4 Q NO-15	Have you taken treatment for this ailment? Q NO-16	What is the main source of treatment Q NO- 17	How much on average do you pay for this treatment.? Q NO-18	Who pays for your treatment? Self = 01 Spouse = 02 Son = 03 Daughter =04 Other =05 Q NO-19	What is the main reason you are not receiving any treatment? QNO -20
1.	Arthritis	y-1 n-2		y-1 n-2go to q no 20				
2.	Diabetes	y-1 n-2		y-1 n-2-go to qstn no20				
3.	Asthama	y-1 n-2		y-1 n-2-go to qstn no20				
4.	High blood pressure	y-1 n-2		y-1 n-2-go to qstn no20				
5.	Cancer	y-1 n-2		y-1 n-2-go to qstn no20				
6.	Cataract	y-1 n-2		y-1 n-2-go to qstn no20				
7.	Loss of natural teeth	y-1 n-2		y-1 n-2-go to qstn no20				
8.	Dementia	y-1 n-2		y-1 n-2-go to qstn no20				
9.	Accidental injury (in the last one /six month)	y-1 n-2		y-1 n-2-go to qstn no20				

Code for q no -17

Government hospital/ Clinic 01
Private hospital/ clinic 02
Ritualistic healing 03
Un-qualified medical practitioner…...04
Sc/phc…….05

APPENDIX-4

HEALTH CARE UTILISATION

OUT PATIENT

Q1	Were you sick for any time during the last one month?	Yes-1 N0-2		
Q2	How many times have you been sick in the last one month?			
Q 3	What was your ailment each time?			
Q 4	Did you take any treatment for your illness?	Yes-1 No-2		
Q5	How many times did you visit a health care provider for treatment?			
Q6	Where did you go for treatment ? Clinic……1 Staff at sc or phc……2 Private hospital……..3 Govt hospital……..4 Ritualistic treatment……..5			
Q 7	How much time you wait to meet the doctor?			
Q 8	Who accompanied you during each episode? None ……1 Childrens….2			
Q9	How much did you spend for treatment? **Consultation** **Medicines** **Lab, xray, and other diagnostics** **Transportation** **Other _____** f. Total			
Q 10	Is the available in all times in govt medicals?			
Q 11	Are the medicines are provided in free of costin gov. medicals?			
IN PATIENT				
Q 1	Have you been hospitalised due to ANY illness within six month. Yes-1 No-2			
Q 2	What was your ailment each time?			
Q 3	What was the type of hospital? Govt hospital……1 Clinic……2 Private hospital……3 Sc/phc……4 Traditional healer……..5 Unqualified medical practitioner…….6			
Q14	Who took you to the hospital? Self…..1 Children….2 Other….3			
Q15	What was the duration of stay in hospital? (IN DAYS)			
Q16	Who stayed with you in the hospital to take care of you? No ne……1 Children……2			
Q17	How much did you spend for treatment? Consultation Medicines Lab, xray, and other diagnostics Hospitalisation Transportation	a._____Rs b._____Rs c._____Rs d._____Rs e._____Rs f._____Rs	a._____Rs b._____Rs c._____Rs d._____Rs e._____Rs f._____Rs	a._____Rs b._____Rs c._____Rs d._____Rs e._____Rs f._____Rs

	Food Other_____ Total Expenditure….	g._____Rs h_____Rs i_____Rs	g._____Rs h_____Rs i_____Rs	g._____.Rs h_____Rs i_____Rs
Q18	Who paid for your treatment? Self ……. 1 Children…….2 Other……..3			
Q19	What is the reason for not taking any treatment? No medical facility available…….1 Facility available but lack of faith……..2 Long waiting……..3 Ailment is not very serious……4			